Testimony of Secretary JudyAnn Bigby
Executive Office of Health and Human Services
Special Commission on Health Care Payment System
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Good afternoon Chairwomen Iselin and Kirwan and other members of the Commission.

I appreciate the opportunity to testify before you today. The task at hand is challenging, but now is the time to make major changes to the health care system as Massachusetts has achieved near universal coverage. While this is an amazing accomplishment in and of itself, we must address how care is delivered in order to address inconsistent quality in care; rates of errors and other adverse events; and the costs of medical care. Simply put, we must change the system to deliver high-value health care that is less costly, more efficient, more equitable, and produces better health outcomes.

The fee-for-service (FFS) payment system in which doctors and other providers are paid for each service provided is increasingly seen as a barrier to effective, coordinated, and efficient care. FFS rewards the misuse, overuse and duplication of services and favors costly, specialized treatment over preventive and primary care. It does not reward providers for keeping patients from being hospitalized, or rehospitalized, or for helping patients control and monitor their chronic conditions. Changing the way we pay for health care by moving away from a primarily fee-for-services system is the only way we can achieve transformation to a better system of care.

Payment reform should push the system away from disorganized, poorly coordinated, and inefficient care; away from care that fails to take into consideration patient preferences resulting in unnecessary and unwanted procedures and interventions, away from policies that result in an undersupply of primary care providers and an oversupply of specialists, and away from care that is delivered without attention to clinical science.

As the whole nation has learned from the work of the Dartmouth Atlas Project, there is huge variation in medical practice that drives up the cost of health care. This variation is due to care that is determined by the physicians who are offering the care. The frequency of discretionary procedures depends less on informed patient choice but more on physician opinion. This leads to the misuse of care. Another contributor to variability in medical practice is the phenomenon of supply-sensitive care. The use of specialists, technology, surgeries, and ICU beds, for example, is strongly influenced by capacity, rather than medical evidence of value and improved outcomes. Much of supply sensitive driven care has no impact on health and can lead to poorer health outcomes, such as health care-associated infections and other adverse events.

We must reform the way we pay for care to move away from these costly realities about our current system. It is imperative that we address misalignment of incentives in our fee-for service system by aligning incentives with quality and efficiency.

An All-Payer Provider Payment System represents a dramatic change in the way we pay for care that could align incentives toward a more integrated health care delivery system, more equitable distribution of

payments to specialist and non-specialist providers within systems, as well as more equitable payments across systems all based on efficiency and quality. In this system, all payers would adopt the same payment rates and methods for hospitals, other institutions, and physicians. Ideally, Massachusetts would have the authority to control Medicare payment rates and methods, as well, in acknowledgement of the important role that Medicare plays in setting policy and standards for both payment and quality. This option could provide higher payments for Medicaid patients and reduce cost shifting to private insurers to offset Medicaid and other shortfalls. It would also address the fragmented system under which providers must deal with numerous payment mechanisms and reporting rules. In order to protect safety net providers, some of the cost savings that arise from this method would have to be directed to providers who care for more vulnerable populations and provide a disproportionate share of mental health and other historically under reimbursed services. This model recognizes a pluralistic system in which private payers and public payers collaborate to pay for care in a variety of settings both public and private.

With this methodology, payments to providers would be made based on Episode-of-Care Payment, a fixed prospective payment per episode of care. This policy would change payment methods to reward and encourage more efficient, coordinated care and promote an integrated delivery system where providers are working in partnership to care for patients across the system, instead of each provider being paid for the piece of care he or she delivers in isolation. Payment for episodes of care — the total cost of hospital services, physician services, and other services required for treating acute conditions or the total cost for all the care

required during a given year for a patient with chronic conditions — with adjustment for complexity of the case mix of patients would reward providers who have lower costs while penalizing higher-cost providers. The Commission should explore how payments to teaching hospitals or other providers for additional services, such as teaching, research, or care of the uninsured, would be addressed by a global fee.

The major issue in designing payment systems for care episodes is assigning accountability for care across different settings and over time. Having a regular source of care and continuous care with the same physician over time have been associated with better health outcomes and lower total costs. The cost of care and rates of medical errors, by contrast, are greater when patients are cared for by many physicians. In this model there is an opportunity to strengthen primary care and care coordination. Reimbursement to primary care physicians would reflect the increase in our understanding of the value of prevention and chronic care management over the last two decades. Instead of paying a provider to see a patient every 15 minutes, reimbursement would support enhanced primary care services, such as care coordination, care management, and easy access to appropriate care. Physicians and practices would be rewarded for providing care that is accessible, centered on patients and families, comprehensive and continuous, coordinated, equitable, and culturally sensitive.

In the end, incentives should support full vertical and horizontal integration of providers and services, with patients having access at multiple, connected points. Care is more coordinated for patients who seek it from more organized delivery models, such as integrated delivery systems and large physician group practices, or from practices where physicians or

community clinicians serve as medical homes and take the responsibility for care coordination. Delivery of care within and among provider organizations, and ensuring care coordination across sites of care, especially when transitioning from the hospital to other settings, should be a key objective of system redesign.

We cannot take full advantage of the use of computer order entry (COE) and electronic health records (EHR) unless we have an integrated system. COE and HER developed at the organizational level can help to reduce costs and improve safety and efficiency. In order for the health system to maximize benefits from these individual systems, however, all pieces must be linked into an interoperable network.

Our current system, where most patients with complex health problems must arrange for the care they need, does not serve people well. Failure to improve the health care system will result in continued preventable mortality and morbidity, excess costs and unnecessary, wasteful expenditures.

Thank you for your attention.